NEVADA CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC (CCBHC) COST REPORT TRAINING

June 2, 2016

OVERVIEW

- Protecting Access to Medicare Act (PAMA) 2014/CCBHC Demonstration Program
- Nevada CCBHC Rate Setting Objectives
- Prospective Payment System (PPS) Rate
- CCBHC Required Services
- CCBHC Cost Report Walk-Through
- Quality Bonus Payment Option
- PPS/Managed Care Integration
- CCBHC Resources

PROTECTING ACCESS TO MEDICARE ACT (PAMA) OF 2014, EFFECTIVE APRIL 1, 2014 (P.L. 113-93, SECTION 223)

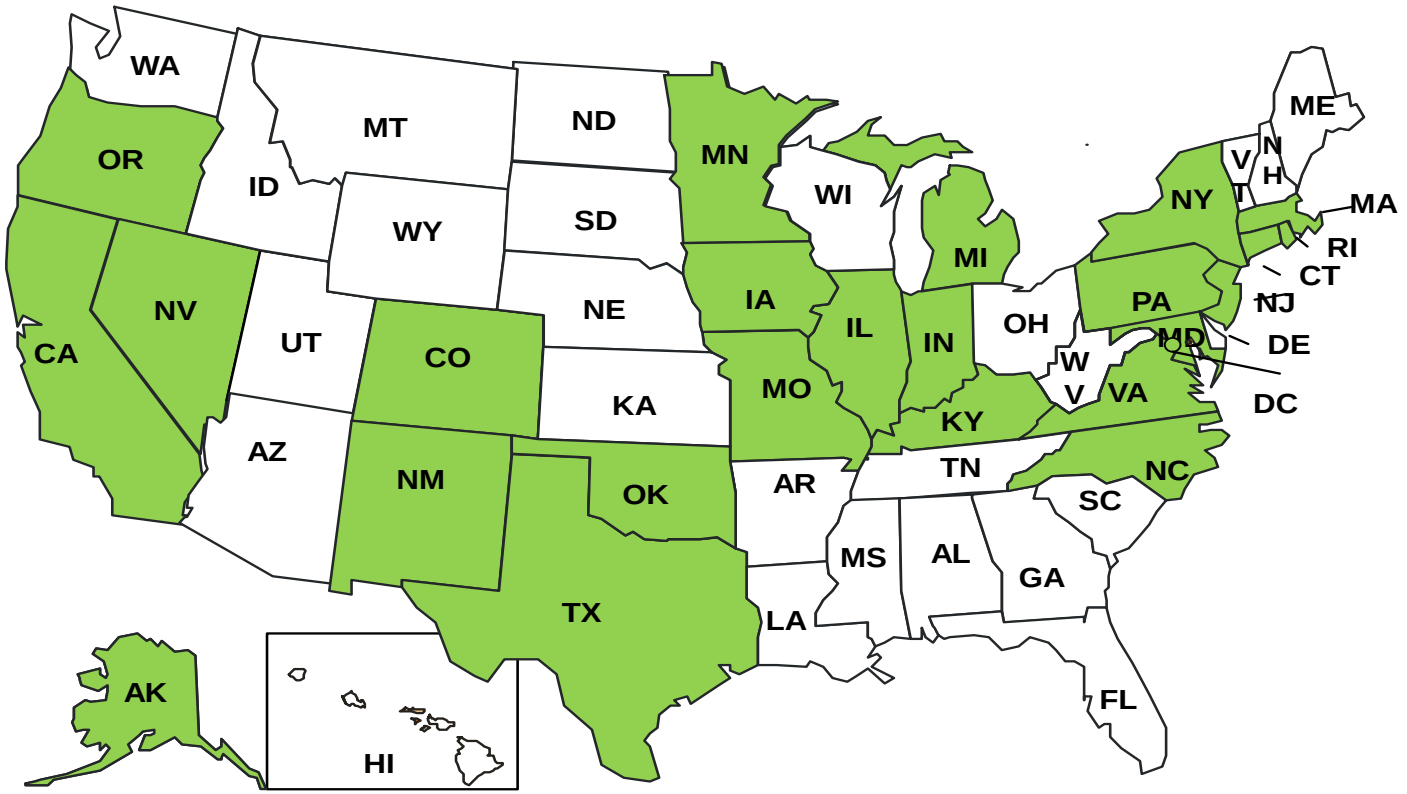
- Establish criteria that states will use to certify community behavioral health clinics that will participate in two year demonstration programs to improve community behavioral health services
- Provide guidance on the development of a Prospective Payment System (PPS)
- Award grants to states for planning purposes and to develop proposals to participate in demonstration program
- Select up to eight states to participate in the demonstration program
- Pay states participating in the demonstration program federal matching funds equivalent to the standard Children's Health Insurance Program (CHIP) matching rate for services, with some exceptions
- Evaluate the project and prepare annual reports to Congress

CCBHC PROGRAM PHASES

Two Phase CCBHC Demonstration Program authorized by the PAMA

- **Phase 1:** Planning Phase
- **Phase 2:** Demonstration Phase

24 States Awarded Planning Grants for CCBHCs



Eight states will be selected for the demonstration program

PLANNING GRANT

1. Engage stakeholders and coordinate activities across agencies to ensure services are accessible and available

2. **Establishment of a PPS for demonstration reimbursable services**

3. Certify community behavioral health clinics using specified criteria

4. Submit an application to participate in the two year demonstration program (October 2016)

DEMONSTRATION PROGRAM

- Up to eight states will be selected to participate in the CCBHC demonstration

- Demonstration states will bill Medicaid under a PPS rate at an enhanced Medicaid Federal Medical Assistance Percentage (FMAP)

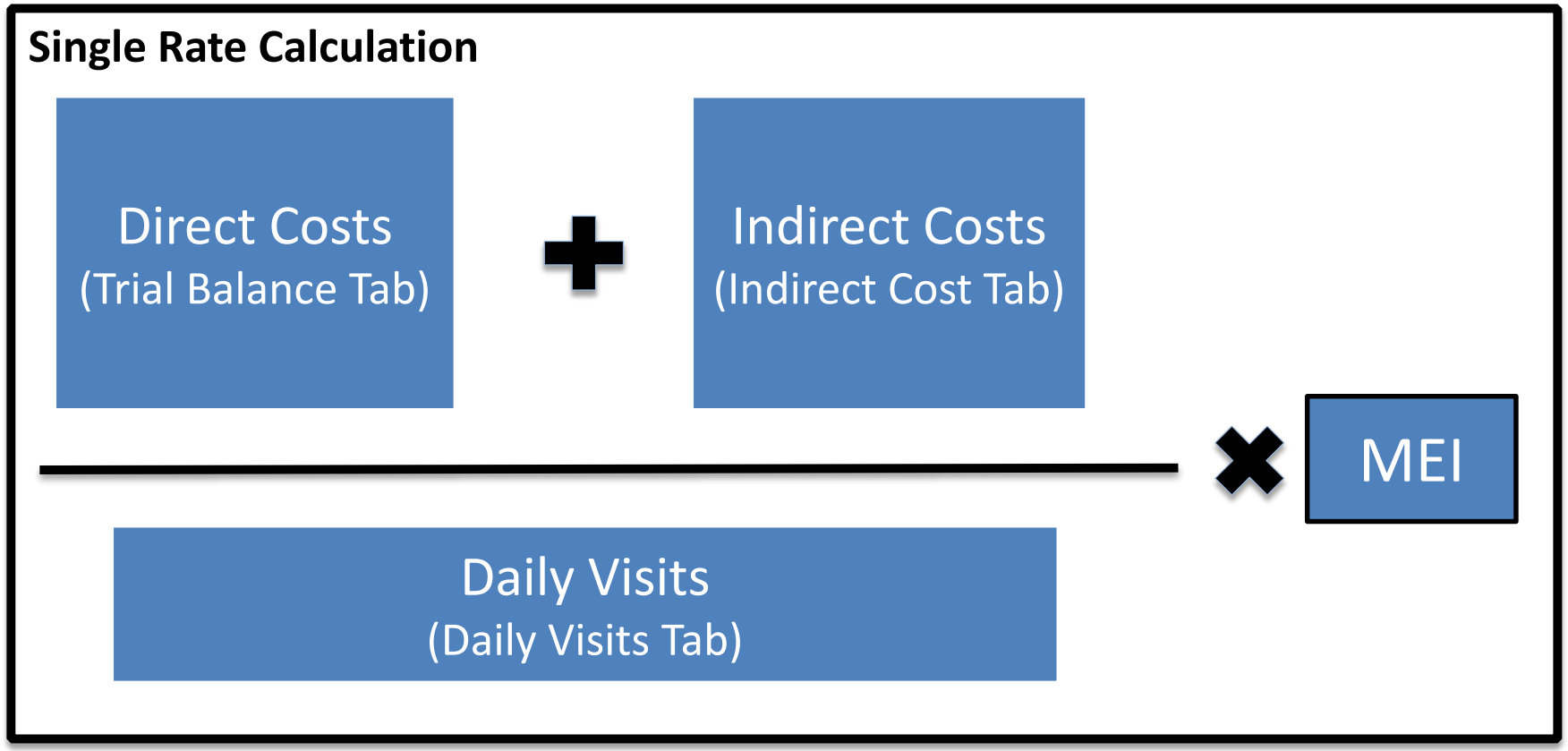
NEVADA CCBHC RATE-SETTING OBJECTIVES

- Cost Report Development & PPS
- Quality-Based Incentive Payment Component – Quality Bonus Payments
- Integrate PPS Methodology Into Managed Care

CCBHC PROSPECTIVE PAYMENT SYSTEM (PPS) RATE ELEMENTS

Rate Element	Description	CCBHC Cost Report
CC PPS-1 Base Rate	Daily Rate - *Uniform payment per day, regardless of the intensity of services or individual needs of clinic users*	1. Utilized to calculate the PPS base rate 2. To be completed by CCBHCs 3. Format developed by CMS
Base Rate Update Factor	Medicare Economic Index (MEI) adjustment or rebasing	N/A
Quality Bonus Payment (QBP)	Optional bonus payment for CCBHCs that meet quality measures	N/A

CC PPS-1 RATE CALCULATION



CCBHC REQUIRED SERVICES

Services	Provided by	
	CCBHC Directly	CCBHC and/or DCO
Crisis mental health services including 24-hour mobile crisis teams, emergency crisis intervention and crisis stabilization intervention and crisis stabilization	✓	
Screening, assessment and diagnosis including risk management	✓	
Patient-centered treatment planning	✓	
Outpatient mental health and substance use services	✓	
Outpatient clinic primary care screening and monitoring of key health indicators and health risk		✓
Targeted case-management		✓
Psychiatric rehabilitation services		✓
Peer support, counseling services, and family support services		✓
Intensive, community-based mental health care for members of the armed forces and veterans, particularly in rural areas; care consistent with minimum clinical mental health VA guidelines		✓

CCBHC REQUIRED SERVICES (CONTINUED)

NOTE: The State of Nevada Division of Public and Behavioral Health (DPBH) and Department of Health Care Financing and Policy (DHCFP) have developed a preliminary list of procedure codes identified as allowable CCBHC services within the nine required services. The link to this listing is included in the "Resources" slide at the end of the presentation.

CCBHC COST REPORT WALK-THROUGH

COST REPORT 2016 TIMELINE

June 2: CCBHC Cost Report Training Webinar

June 2 – July 15: Nevada Prospective CCBHCs complete/submit CCBHC cost reports

July 16 – August 15: Myers and Stauffer performs desk reviews (and on-site reviews if determined necessary)

August 16 – September 15: PPS Rates finalized by Myers and Stauffer

CCBHC COST REPORT DOCUMENTS

Complete CCBHC Cost Report Submission (Due July 15) includes:

1. CCBHC Cost Report
2. Accompanying Support:

- Detailed Trial Balance
- Crosswalk/Mapping between the Trial Balance and the Cost Report by Cost Center (should include a reconciliation of Trial Balance and Cost Report Differences)
- Patient Visit Report
- Explanation, calculations, and supporting documentation for reclassifications, adjustments, and anticipated costs
- Explanation and calculation details for estimated Designated Collaborating Organizations (DCOs)

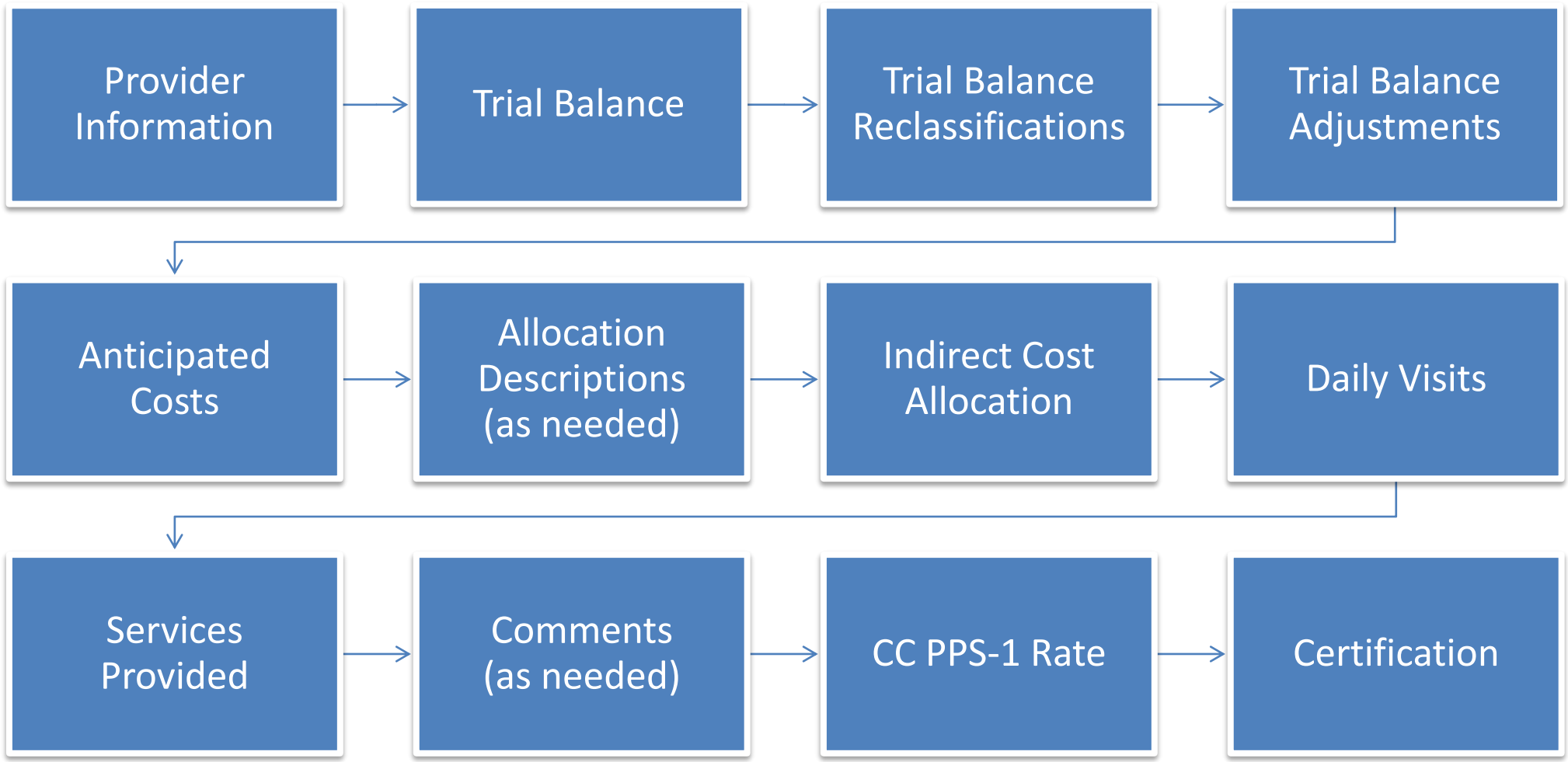
CCBHC COST REPORT REGULATIONS

When reporting costs, the CCBHC must adhere to:

1. 45 Code of Federal Regulations (CFR) §75 Uniform Administrative Requirements, Cost Principles, and Audit Requirements for the U.S. Department of Health and Human Services (HHS) Awards

2. 42 CFR §413 Principles of Reasonable Cost Reimbursement

COST REPORT STEPS/SCHEDULES



Provider Information – Part 1

- Use the Provider Information tab (Parts 1 and 2) to report CCBHC-identifying information for all of the CCBHC's primary and satellite center locations
- Part 1 is for single sites or central office information

→ PPS-1

CCBHC Cost Report				
MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	Provider Information			
PPS METHODOLOGY:				
This box for state use only - LEAVE BLANK				
Select type of oversight:		Audited		Desk Reviewed
Date reviewed:				

PART 1 - PROVIDER INFORMATION (Consolidated)				
1.	Name:			
2.	Street:		P.O. Box:	
3.	City:	State:	Zip Code:	
4.	County:			
5.	Medicaid ID:			
6.	NPI:			
7.	Location designation (see Cost Report Instructions):			
8.	Organizational authority (see Cost Report Instructions):			
9.	Behavioral health professionals (see Cost Report Instructions):			

	Name 1	NPI 2
9a		
9b		
9c		
9d		
9e		

Insert additional behavioral health professionals

Organizational Authority Codes

Code	Organizational Authority Description
1	Nonprofit
2	Local government behavioral health authority
3	Indian Health Service organization
4	Indian tribe or tribal organization
5	Urban Indian organization

Provider Information – Part 2

CCBHC Cost Report					
MEDICAID ID:					
NPI:					
REPORTING PERIOD:	From:		To:		
PART 2 – PROVIDER INFORMATION FOR CLINICS FILING UNDER CONSOLIDATED COST REPORTING (For additional satellite sites, create new tab and copy and paste Part 2 for each additional site included)					
Site-Specific Information					
1. Was this site in existence before April 1, 2014? (No payment will be made to satellite facilities of CCBHCs established after April 1, 2014).					
2. Name:					
3. Street:				P.O. Box:	
4. City:		State:		Zip Code:	
5. County:					
6. Medicaid ID:					
7. NPI:					
8. Location designation (see Cost Report Instructions):					
9. Organizational authority (see Cost Report Instructions):					
10. Is the CCBHC dually certified as a 1905(a)(9) clinic?					
11. Does the site operate as other than CCBHC?					
12. If line 11 is "Yes", specify the type of operation (e.g., clinic, FQHC, other):					
13. Identify days and hours the site operates as a CCBHC by listing the time next to the applicable day					
	Days		Hours of Operation From	Hours of Operation To	Total Hours
13a	Sunday				
13b	Monday				
13c	Tuesday				
13d	Wednesday				
13e	Thursday				
13f	Friday				
13g	Saturday				
14. Identify days and hours the site operates as other than a CCBHC by listing the time next to the applicable day					
	Days		Hours of Operation From	Hours of Operation To	Total Hours
14a	Sunday				
14b	Monday				
14c	Tuesday				
14d	Wednesday				
14e	Thursday				
14f	Friday				
14g	Saturday				
OMB #0398-1148 CMS-10398 (#43)					
End of Worksheet					

- Part 2 is if the entity is filing a consolidated report and should be completed for every additional site. Tab should be copy and pasted for each location

Trial Balance Part 1A

CCBHC STAFF COSTS

This information must correspond with the Mapping of Trial Balance Costs

This information must correspond with the Trial Balance Reclassifications/Adjustments Tab(s)

PART 1 - DIRECT CCBHC EXPENSES

PART 1A - CCBHC STAFF COSTS

	Description	Compensation 1	Other 2	Total (Col. 1 + 2) 3	Reclassifications 4	Reclassified Trial Balance (Col. 3 + 4) 5	Adjustments Increases (Decreases) 6	Adjusted Amount (Col. 5 + 6) 7	Adjustments for Anticipated Cost Changes 8	Net Expenses (Col. 7 + 8) 9
1.	Psychiatrist	$ 400,000		$ 400,000	$ (28,800)	$ 371,200		$ 371,200	$ 130,000	$ 501,200
2.	Psychiatric nurse			$ -		$ -		$ -	$ 65,000	$ 65,000
3.	Child psychiatrist			$ -		$ -		$ -		$ -
4.	Adolescent psychiatrist			$ -		$ -		$ -		$ -
5.	Substance abuse specialist	$ 75,000		$ 75,000		$ 75,000		$ 75,000		$ 75,000
6.	Case manager			$ -		$ -		$ -	$ 50,000	$ 50,000
7.	Recovery coach			$ -		$ -		$ -		$ -
8.	Peer specialist			$ -		$ -		$ -		$ -
9.	Family support specialist			$ -		$ -		$ -		$ -
10.	Licensed clinical social worker			$ -		$ -		$ -		$ -
11.	Licensed mental health counselor	$ 72,000		$ 72,000		$ 72,000		$ 72,000		$ 72,000
12.	Mental health professional (trained and credentialed for psychological testing)			$ -		$ -		$ -		$ -
13.	Licensed marriage and family therapist			$ -		$ -		$ -		$ -
14.	Occupational therapist			$ -		$ -		$ -		$ -
15.	Interpreter or linguistic counselor			$ -		$ -		$ -		$ -
16.	General practice (performing CCBHC services)			$ -		$ -		$ -		$ -
17.	Other staff costs (specify details below)									
17a				$0		$0		$0		$0
17b				$0		$0		$0		$0
	Insert additional line for *other* staff costs									
18.	Subtotal staff costs (sum of lines 1-17)	**$547,000**	**$0**	**$547,000**	**-$28,800**	**$518,200**	**$0**	**$518,200**	**$245,000**	**$763,200**

- This section is used to report CCBHC Staff Costs & also Shows Staff Reclassifications, Adjustments, & Adjustments for Anticipated Costs Changes

This information must correspond with the Anticipated Costs Tab

STEPS TO CREATING A CROSSWALK & MAPPING

Step 1: List all Trial Balance Accounts

Step 2: Identify the appropriate Cost Report Line & description beside each Trial Balance Account (See Cost Report Instructions)

Step 3: Summarize costs by Cost Report Cost Line

Trial Balance/Crosswalk/Mapping

Step 1

Example Provider
Trial Balance
FYE 20XX

Account Number	General Ledger Account Title	Trial Balance
2000	**Other Revenue**	(125)
3000	**Outpatient Clinic**	(1,252,000)
6000	**Psychiatrist Salary Expense**	400,000
6100	**Mental Health Counselor Salary Expense**	72,000
6110	**Office Admin Salaries**	90,000
6120	**Janitor/Housekeeping Salaries**	31,200
6200	**CADC Salary Expense**	75,000
7030	**Equipment Expense - Office Equipment**	2,700
7040	**Equipment Expense - Computer Hdwr/Soft**	3,200
7110	**Office Supplies**	6,500
7111	**Postage**	200
7115	**Bank Fees**	2,500
7116	**Printing Costs**	3,000
7120	**Medical Supplies**	225,000
7310	**Patient Transportation**	620
7450	**M & R - Building Maintenance**	2,100
7540	**Contracted Services - Accounting/Audit**	3,100
7545	**Contracted Services - Legal Fees**	22,300
7575	**Electronic Claims processing**	19,500
7610	**Rent**	3,900
7620	**Utilities**	3,100
7630	**Trash Pickup**	3,300
7640	**Housekeeping Expenses**	5,000
7650	**Telephone**	1,800
7700	**Insurance Expense**	32,000
8800	**Depreciation - Medical Equip**	1,400

Step 2

Crosswalk

Cost Report Line.Col	Cost Report Description
N/A	Revenue Account
N/A	Revenue Account
1.1	Psychiatrist
11.1	Licensed mental health counselor
40.1	Office salaries
36.1	Housekeeping and maintenance
5.1	Substance abuse specialist
42.2	Office supplies
42.2	Office supplies
42.2	Office supplies
42.2	Office supplies
47a.2	Bank Fees
42.2	Office supplies
22.2	Medical supplies
23.2	Transportation (health care staff)
36.2	Housekeeping and maintenance
44.2	Accounting
43.2	Legal
27a.2	Electronic Health Records Costs
30.2	Rent
33.2	Utilities
36.2	Housekeeping and maintenance
36.2	Housekeeping and maintenance
46.2	Telephone
45.2	Insurance
24.2	Depreciation - medical equipment

Step 3

Mapping

	Cost Report Total	Cost Report Line.Col	Cost Report Description
$	400,000	1.1	Psychiatrist
$	72,000	11.1	Licensed mental health counselor
$	75,000	5.1	Substance abuse specialist
$	225,000	22.2	Medical supplies
$	620	23.2	Transportation (health care staff)
$	1,400	24.2	Depreciation - medical equipment
$	19,500	27a.2	Medical Equipment Rental
$	3,900	30.2	Rent
$	3,100	33.2	Utilities
$	31,200	36.1	Housekeeping and maintenance
$	10,400	36.2	Housekeeping and maintenance
$	90,000	40.1	Office salaries
$	15,600	42.2	Office supplies
$	22,300	43.2	Legal
$	3,100	44.2	Accounting
$	32,000	45.2	Insurance
$	1,800	46.2	Telephone
$	2,500	47a.2	Bank Fees
$	**1,009,420**	**Trial Balance Tab, Line 53, Col. 3**	

Trial Balance Part 1B

This information must correspond with your Mapping of Trial Balance Costs

This information must correspond with the Trial Balance Reclassifications/Adjustments Tab(s)

CCBHC COSTS UNDER AGREEMENT

PART 1B - CCBHC COSTS UNDER AGREEMENT

	Description	Compensation 1	Other 2	Total (Col. 1 + 2) 3	Reclassifications 4	Reclassified Trial Balance (Col. 3 + 4) 5	Adjustments Increases (Decreases) 6	Adjusted Amount (Col. 5 + 6) 7	Adjustments for Anticipated Cost Changes 8	Net Expenses (Col. 7 + 8) 9
19.	CCBHC costs from DCO			$0		$0		$0		$0
20.	Other CCBHC costs (specify details below)									
20a				$0		$0		$0		$0
	Insert additional line for *other* CCBHC costs under agreement									
21.	Subtotal costs under agreement (sum of lines 19-20)		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

PART 1C - OTHER DIRECT CCBHC COSTS

	Description	Compensation 1	Other 2	Total (Col. 1 + 2) 3	Reclassifications 4	Reclassified Trial Balance (Col. 3 + 4) 5	Adjustments Increases (Decreases) 6	Adjusted Amount (Col. 5 + 6) 7	Adjustments for Anticipated Cost Changes 8	Net Expenses (Col. 7 + 8) 9
22.	Medical supplies		$ 225,000	$ 225,000		$ 225,000	$ (125)	$ 224,875		$ 224,875
23.	Transportation (health care staff)		$ 620	$ 620		$ 620		$ 620		$ 620
24.	Depreciation - medical equipment		$ 1,400	$ 1,400		$ 1,400		$ 1,400		$ 1,400
25.	Professional liability insurance			$ -		$ -		$ -		$ -
26.	Telehealth			$ -		$ -		$ -		$ -
27.	Other direct costs not already included (specify details below)									
27a	Electronic Health Records Costs		$ 19,500	$ 19,500		$ 19,500		$ 19,500	$ 35,000	$ 54,500
27b				$ -		$ -		$ -		$ -
	Insert additional line for *other* direct CCBHC costs									
28.	Subtotal other direct CCBHC costs (sum of lines 22-27)		**$246,520**	**$246,520**	**$0**	**$246,520**	**-$125**	**$246,395**	**$35,000**	**$281,395**
29.	**Total cost of CCBHC services (other than overhead) (sum of lines 18, 21, and 28)**	**$547,000**	**$246,520**	**$793,520**	**-$28,800**	**$764,720**	**-$125**	**$764,595**	**$280,000**	**$1,044,595**

This information must correspond with the Anticipated Costs Tab

Trial Balance Part 2A/2B

INDIRECT SITE COSTS

This information must correspond with your Mapping of Trial Balance Costs

This information must correspond with the Trial Balance Reclassifications/Adjustments Tab(s)

PART 2 - INDIRECT COSTS

PART 2A - SITE COSTS

	Description	Compensation 1	Other 2	Total (Col. 1 + 2) 3	Reclassifications 4	Reclassified Trial Balance (Col. 3 + 4) 5	Adjustments Increases (Decreases) 6	Adjusted Amount (Col. 5 + 6) 7	Adjustments for Anticipated Cost Changes 8	Net Expenses (Col. 7 + 8) 9
30.	Rent		$ 3,900	$ 3,900		$ 3,900		$ 3,900		$ 3,900
31.	Insurance			$ -		$ -		$ -		$ -
32.	Interest on mortgage or loans			$ -		$ -		$ -		$ -
33.	Utilities		$ 3,100	$ 3,100		$ 3,100		$ 3,100		$ 3,100
34.	Depreciation - buildings and fixtures			$ -		$ -		$ -		$ -
35.	Depreciation - equipment			$ -		$ -		$ -		$ -
36.	Housekeeping and maintenance	$ 31,200	$ 10,400	$ 41,600		$ 41,600		$ 41,600		$ 41,600
37.	Property tax			$ -		$ -		$ -		$ -
38.	Other site costs (specify details below)									
38a				$0		$0		$0		$0
	Insert additional line for *other* site costs									
39.	Subtotal site costs (sum of lines 30-38)	**$31,200**	**$17,400**	**$48,600**	**$0**	**$48,600**	**$0**	**$48,600**	**$0**	**$48,600**

PART 2B - ADMINISTRATIVE COSTS

	Description	Compensation 1	Other 2	Total (Col. 1 + 2) 3	Reclassifications 4	Reclassified Trial Balance (Col. 3 + 4) 5	Adjustments Increases (Decreases) 6	Adjusted Amount (Col. 5 + 6) 7	Adjustments for Anticipated Cost Changes 8	Net Expenses (Col. 7 + 8) 9
40.	Office salaries	$ 90,000		$ 90,000	$ 28,800	$ 118,800		$ 118,800		$ 118,800
41.	Depreciation - office equipment			$ -		$ -		$ -		$ -
42.	Office supplies		$ 15,600	$ 15,600		$ 15,600		$ 15,600		$ 15,600
43.	Legal		$ 22,300	$ 22,300		$ 22,300		$ 22,300		$ 22,300
44.	Accounting		$ 3,100	$ 3,100		$ 3,100		$ 3,100		$ 3,100
45.	Insurance		$ 32,000	$ 32,000		$ 32,000		$ 32,000		$ 32,000
46.	Telephone		$ 1,800	$ 1,800		$ 1,800		$ 1,800		$ 1,800
47.	Other administrative costs (specify details below)									
47a	Bank Fees		$2,500	$2,500		$2,500	$ (60)	$2,440		$2,440
47b				$0		$0		$0		$0
	Insert additional line for *other* administrative costs									
48.	Subtotal administrative costs (sum of lines 40-47)	**$ 90,000**	**$ 77,300**	**$ 167,300**	**$ 28,800**	**$ 196,100**	**$ (60)**	**$ 196,040**	**$ -**	**$ 196,040**
49.	**Total overhead (sum of lines 39 and 48)**	**$ 121,200**	**$ 94,700**	**$ 215,900**	**$ 28,800**	**$ 244,700**	**$ (60)**	**$ 244,640**	**$ -**	**$ 244,640**

- Indirect Costs – Cost incurred to *support* the providing of a service:
  - Rental costs,
  - Utility costs,
  - Administrative personnel costs

This information must correspond with the Anticipated Costs Tab

Trial Balance Part 3A/3B

DIRECT COSTS FOR NON-CCBHC SERVICES

- This section is used to report direct costs for non-CCBHC services both covered & non-reimbursable by Medicaid.

PART 3 - DIRECT COSTS FOR NON-CCBHC SERVICES

PART 3A - DIRECT COSTS FOR SERVICES OTHER THAN CCHBC SERVICES

	Description	Compensation 1	Other 2	Total (Col. 1 + 2) 3	Reclassifications 4	Reclassified Trial Balance (Col. 3 + 4) 5	Adjustments Increases (Decreases) 6	Adjusted Amount (Col. 5 + 6) 7	Adjustments for Anticipated Cost Changes 8	Net Expenses (Col. 7 + 8) 9
50.	Direct costs for non-CCBHC services covered by Medicaid (specify details below)									
50a				$0		$0		$0		$0
	Insert additional line for direct costs for non-CCBHC services covered by Medicaid									

PART 3B - NON-REIMBURSABLE COSTS

	Description	Compensation 1	Other 2	Total (Col. 1 + 2) 3	Reclassifications 4	Reclassified Trial Balance (Col. 3 + 4) 5	Adjustments Increases (Decreases) 6	Adjusted Amount (Col. 5 + 6) 7	Adjustments for Anticipated Cost Changes 8	Net Expenses (Col. 7 + 8) 9
51.	Direct costs for non-CCBHC services *not* covered by Medicaid (specify details below)									
51a				$0		$0		$0		$0
	Insert additional line for direct costs for non-CCBHC services *not* covered by Medicaid									
52.	Total costs for non-CCBHC services (sum of lines 50-51)	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
53.	**Total costs (sum of lines 29, 49, and 52)**	$ 668,200	$ 341,220	$ 1,009,420	$ -	$ 1,009,420	$ (185)	$ 1,009,235	$ 280,000	$ 1,289,235

OMB #0398-1148 CMS-10398 (#43)

End of Worksheet

This total must correspond with total costs on your Mapping of Trial Balance Costs

Trial Balance Reclassifications

CCBHC Cost Report				
MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	Trial Balance Reclassifications			

	Explanation of Entry	Increase: Expense Category 1	Increase: Line Number 2	Increase: Amount* 3	Decrease: Expense Category 4	Decrease: Line Number 5	Decrease: Amount* 6
1.							
2.							
3.							
4.							
5.							
6.							
7.							

- Used to reclassify the expenses listed on the Trial Balance tab
- Reclassify costs where expenses are applicable to more than one expense category

Example

	Explanation of Entry	Increase: Expense Category 1	Increase: Line Number 2	Increase: Amount* 3	Decrease: Expense Category 4	Decrease: Line Number 5	Decrease: Amount* 6
1.	Medical Director	Office Salaries	40.00	$ 28,800.00	Psychiatrist	1.00	$(28,800.00)

Trial Balance Adjustments

- Use to adjust the expenses listed on Trial Balance tab

Example

45 CFR 75.406 Applicable Credits.— Applicable credits refer to those receipts or reduction-of-expenditure-type transactions that offset or reduce expense items allocable to the Federal award as direct or indirect F&A costs. Examples of such transactions are: purchase discounts, **rebates**, or allowances; recoveries or indemnities on losses; insurance refunds or rebates and; adjustments of overpayments or erroneous charges.

PART 1 - COMMON ADJUSTMENTS					
	Description	Basis for Adjustment* 1	Amount** 2	Expense Classification*** 3	Line Number 4
1.	Investment income on commingled restricted and unrestricted funds				
2.	Trade, quantity, and time discounts on purchases				
3.	Rebates and refunds of expenses	B	$ (125)	Medical Supplies	22.00
4.	Rental of building or office space to others				
5.	Home office costs				
6.	Adjustment resulting from transactions with related organizations				
7.	Vending machines				
8.	Practitioner assigned by National Health Service Corps				
9.	Depreciation - buildings and fixtures				
10.	Depreciation - equipment				
11.	Other common adjustments (specify details below)				
11a	Electronic Health Records Costs				
11b					
	Insert additional line for *other* items				
12.	Subtotal of common adjustments (sum of lines 1-11)		$ (125)		

General Ledger Account Affected	Account Description	Reason for Adjustment	Amount	Column	Line Number
7115	**Bank Fees**	Late Fees	$ (60.00)	2	47a
2000	**Other Revenue**	Offset Rebate to Related Expense	$ (125.00)	2	22

Trial Balance Adjustments cont.

PART 2 - COSTS NOT ALLOWED (Must be removed from allowable costs)					
	Description	Basis for Adjustment* 1	Amount** 2	Expense Classification*** 3	Line Number 4
13.	Bad debts	A			
14.	Charitable contributions	A			
15.	Entertainment costs, including costs of alcoholic beverages	A			
16.	Federal, state, or local sanctions or fines	A			
17.	Fund-raising costs	A			
18.	Goodwill, organization costs, or other amortization	A			
19.	Legal fees related to criminal investigations	A			
20.	Lobbying costs	A			
21.	Selling and marketing costs	A			
22.	Subtotal of other costs not allowed (specify details below)				
22a	Non-allowable late fee/penalties	A	$ (60)	Bank Fees	47a
	Insert additional line for *other* items				
23.	Subtotal of costs not allowed (sum of lines 13-22)	A	$ (60)		
24.	Total Adjustments (sum of lines 12 and 23)		$ (185)		
*Basis for adjustment A. Costs - if cost (including applicable overhead) can be determined B. Amount received - if cost cannot be determined					
** Transfer to Trial Balance worksheet, column 6 as appropriate					
*** Expense classification on Trial Balance worksheet from which amount is to be deducted or to which the amount is to be added					
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End of Worksheet					

General Ledger Account Affected	Account Description	Reason for Adjustment	Amount	Column	Line Number
7115	**Bank Fees**	Late Fees	$ (60.00)	2	47a
2000	**Other Revenue**	Offset Rebate to Related Expense	$ (125.00)	2	22

Anticipated Costs

- Used to add or change the expenses listed on Trial Balance tab to allow for services not previously offered but required as a CCBHC
- Estimate changes in cost and FTEs providing CCBHC services

PART 1 - DIRECT CCBHC EXPENSES

PART 1A - CCBHC STAFF COSTS

	Description	Additional Required Full-Time Equivalent (FTE) Staff 1	Additional Expense Amount 2	Reduced Expense Amount 3	Anticipated Changes in Costs Due to Addition of CCBHC Services* (Col. 2 - 3) 4
1.	Psychiatrist	1	$130,000		$130,000
2.	Psychiatric nurse	1	$65,000		$65,000
3.	Child psychiatrist				$0
4.	Adolescent psychiatrist				$0
5.	Substance abuse specialist				
6.	Case manager	1	$50,000		
7.	Recovery coach				
8.	Peer specialist				

Anticipated Cost Increases/Decreases Due to Adding CCBHC Services

Increase: Expense Category 1	**Increase:** Cost Line Number 2	**Increase:** Amount* 3
Psychiatrist	1	$ 130,000.00
Psychiatric nurse	2	$ 65,000.00
Case manager	6	$ 50,000.00
Electronic Health Records	27a	$ 35,000.00

PART 1C - OTHER DIRECT CCBHC COSTS

	Description	Additional Required Full-Time Equivalent (FTE) Staff 1	Additional Expense Amount 2	Reduced Expense Amount 3	Anticipated Changes in Costs Due to Addition of CCBHC Services* (Col. 2 - 3) 4
22.	Medical supplies				$0
23.	Transportation (health care staff)				$0
24.	Depreciation - medical equipment				$0
25.	Professional liability insurance				$0
26.	Telehealth				$0
27.	Other direct costs not already included (specify details below)				
27a	Electronic Health Records Costs		$35,000		$35,000
27b					$0
	Additional lines inserted via Trial Balance tab				
28.	Subtotal other direct CCBHC costs (sum of lines 22-27)		$35,000	$0	$35,000
29.	**Total cost of CCBHC services (other than overhead) (sum of lines 18, 21, and 28)**	$3	$280,000	$0	$280,000

CCBHC Cost Report					
MEDICAID ID:					
NPI:					
REPORTING PERIOD:	From:		To:		
RATE PERIOD:	From:		To:		
WORKSHEET:	Indirect Cost Allocation				

	Description	
1.	Does the CCBHC have a indirect cost rate approved by a cognizant agency (see Cost Report Instructions)? If no, go to line 7.	
2.	Which cognizant agency approved the rate?	
3.	Describe the base rate with respect to the indirect cost rate.	
4.	Enter the basis amount subject to the rate agreement	
5.	Enter the approved rate amount	
6.	Calculated indirect costs allocable to CCBHC services (line 4 multiplied by line 5)	$0
7.	Does the CCBHC qualify to use the federal minimum rate and elect to use the rate for all federal awards? See instructions for qualifications. If no, go to line 11.	
8.	Direct costs for CCBHC services (Trial Balance, column 9, line 29)	$0
9.	Minimum rate	10.0%
10.	Calculated indirect costs allocable to CCBHC services (line 8 multiplied by line 9)	$0
11.	Will the CCBHC allocate indirect costs proportionally by the percentage of direct costs for CCBHC services versus total allowable costs less indirect costs? If no, go to line 15.	
12.	Percentage of direct costs versus total allowable direct costs (Trial Balance, column 9, line 29 divided by the sum of Trial Balance, column 9, line 29 and Trial Balance, column 9, line 52)	0.0%
13.	Indirect costs to be allocated (Trial Balance, column 9, line 49)	$0
14.	Calculated indirect costs allocable to CCBHC services (line 12 multiplied by line 13)	$0
15.	If none of the lines 1, 7, or 11 are entered as Yes, provide a thorough description of the cost allocation method used. Include attachments for descriptions and calculations. Include references to line items included in the Trial Balance tab. Enter the amount of indirect costs allocated to providing CCBHC services here.	
16.	Total indirect costs allocated to CCBHC services	$0

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End of Worksheet

Indirect Cost Allocation

Use to identify the method used for calculating allocable indirect costs to CCBHC services

The worksheet can be used for the following methods of allocation:

- Federally approved indirect cost rate by a cognizant agency
- Minimum rate for qualifying entities (10%)
- Proportionate allocation by percentage of direct costs
- Other, where the entity must provide a description and justification of the allocation method

Allocation Descriptions

CCBHC Cost Report				
MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	Allocation Descriptions			

PLEASE EXPLAIN METHODS USED FOR ALLOCATING RESOURCES TO DIRECT OR INDIRECT COSTS
Justification for allocation:

The purpose of this tab is to expedite cost report review and to limit the questioning of costs

This tab allows the clinic to describe in detail the calculations and methods to support the allocation of direct and indirect costs

Data reported in this tab should support allocations in the Trial Balance, Reclassifications, and Adjustments tabs

Additional anticipated daily visit calculations/estimations should be included on this tab

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End of Worksheet

Daily Visits

CCBHC Cost Report				
MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	Daily Visits			

PATIENT DEMOGRAPHICS CONSOLIDATED		
	Include ALL visits for CCBHC services; do not limit it to those covered by Medicaid.	Patient Visits 1
1.	Number of daily visits for patients receiving CCBHC services provided directly from staff	3
2.	Number of daily visits for patients receiving CCBHC services directly from DCO (not included above)	1
3.	Number of additional anticipated daily visits for patients receiving CCBHC services	
4.	Total daily visits for patients receiving CCBHC services (sum of lines 1-3)	4
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	End of Worksheet	

Use this tab to report the total annual number of daily CCBHC visits delivered to all clinic users that receive demonstration services; includes daily visits of DCOs* and services delivered to non- Medicaid beneficiaries.

* A DCO is an entity that is not under the direct supervision of the CCBHC but is engaged in a formal relationship with the CCBHC and delivers services under the same requirements as the CCBHC.

DETAILED VISIT REPORT (EXAMPLE)

Patient Detail Support for Visits
Provider Name
Cost Report Date (to and from)

Recipient Name	Provider Name	Claim Number	Recipient Patient ID	Member Medicaid ID	Date of Service	Procedure/ CPT Code	Insurance Payor	Billed Amount	Allowed Amount	Paid Amount	1=CCBHC 2=DCO	
John Doe	Dr. ABC	6832	55555555	444444444	3/3/2015	90839	Medicaid	$ 150.00	$ 150.00	$ 60.00	1	
John Doe	Dr. ABC	6832	55555555	444444444	3/3/2015	99366	Medicaid	$ 140.00	$ 110.00	$ 70.00		(same day - above)
John Doe I	Dr. ABC	6900	45454545	N/A	3/15/2015	99366	Private Insurance	$ 140.00	$ 110.00	$ 70.00	1	
Jane Doe	Dr. DEF	6942	66666666	777777777	4/1/2015	99211	Medicaid MCO	$ 50.00	$ 50.00	$ 45.00	1	
John Doe	Dr. ABC	6832	55555555	444444444	4/15/2015	90839	Medicaid	$ 150.00	$ 150.00	$ 60.00		(same day - see DCO below)
										CCBHC Total	3	
										Ties to Daily Visit Sch, Line 1		
John Doe	DCO Provider	6832	55555555	444444444	4/15/2015	90839	Medicaid	$ 90.00	$ 90.00	$ 50.00	2	
										DCO Total	1	
										Ties to Daily Visit Sch, Line 2		

VISIT ENUMERATION

- A visit may only be enumerated when at least one of the statutorily-required services as specified at section 223 (a)(D)* is provided by either a CCBHC or a DCO
  - These refer to the 9 required services listed on slide 11 and then specifically the Nevada allowable CCBHC procedure codes compiled by DHCFP (referenced in slide 12)
- The totals on the Patient Daily Visit Report should tie to lines 1 and 2 of the Daily Visits schedule of the CCBHC cost report. Line 3 (additional anticipated daily visits) should be explained in the “Allocation Descriptions” tab

VISIT DOCUMENTATION

- SAMHSA requires a CCBHC to establish or maintain a health information system that includes, but is not limited to, electronic health records
- All activities that trigger an enumerated visit **must** be documented in the clinic user's medical record

CARE COORDINATION

- Care coordination is a required activity per § 223 (a)(2)(C) but is not a demonstration service that triggers an enumerated visit
- CCBHCs should document all care coordination that supports a demonstration service
- Costs associated with care coordination may be included in total allowed demonstration cost

Services Provided

PART 1 - SERVICES PROVIDED (Consolidated)					
	PART 1A - CCBHC STAFF SERVICES				
	Description	Number of Full-Time Equivalent (FTE) Staff	Total Number of Services Provided for CCBHC Services	Direct Cost (from Trial Balance, Col. 9)	Average Cost per Service by Position (Col. 3 divided by Col. 2)
		1	2	3	4
1.	Psychiatrist	4.0		$ 501,200.00	$ -
2.	Psychiatric nurse	1.0		$ 65,000.00	$ -
3.	Child psychiatrist			$ -	$ -
4.	Adolescent psychiatrist			$ -	$ -
5.	Substance abuse specialist	1.0		$ 75,000.00	$ -
6.	Case manager	1.0		$ 50,000.00	$ -
7.	Recovery coach			$ -	$ -
8.	Peer specialist			$ -	$ -
9.	Family support specialist			$ -	$ -
10.	Licensed clinical social worker			$ -	$ -
11.	Licensed mental health counselor	1.0		$ 72,000.00	$ -
12.	Mental health professional (trained and credentialed for psychological testing)			$ -	$ -
13.	Licensed marriage and family therapist			$ -	$ -
14.	Occupational therapist			$ -	$ -
15.	Interpreters or linguistic counselor			$ -	$ -
16.	General practice (performing CCBHC services)			$ -	$ -
17.	Other staff services (specify details below)				
17a				$ -	$ -
17b				$ -	$ -
	Additional lines inserted via Trial Balance tab				
18.	Subtotal staff services (sum of lines 1-17)	8	0	$ 763,200.00	$ -

- Use the Services Provided tab to report the number of FTEs and the number of services provided for CCBHC services for each type of practitioner

Comments

CCBHC Cost Report				
MEDICAID ID:				
NPI:				
REPORTING PERIOD:	From:		To:	
RATE PERIOD:	From:		To:	
WORKSHEET:	Comments			

Please explain or comment on any additional considerations that should be taken into account in determining the appropriate payment rate

Worksheet	Line	Comment 1	Comment 2	Comment 3	Comment 4	Comment 5	Comment 6	Comment 7	Comment 8	Comment 9

- Use the Comments tab to explain any cost anomalies, entries in “Other (specify)” lines in Trial Balance, Trial Balance Adjustments, Services Provided, or any other considerations the state should make regarding the expenses used to determine the payment rate

CC PPS-1 Rate

Used to determine the all-inclusive CCBHC payment rate per daily visit for the reporting period for states selecting the CC PPS-1 rate method.

PART 1 - DETERMINATION OF TOTAL ALLOWABLE COST APPLICABLE TO THE CCBHC		
	Description	Amount 1
1.	Total direct cost of CCBHC services (Trial Balance, column 9, line 29)	$0
2.	Indirect cost applicable to CCBHC services (Indirect Cost Allocation, line 16)	$0
3.	Total allowable CCBHC costs (sum of lines 1-2)	$0

Determination of Total Allowable Cost Applicable to CCBHC

PART 2 - DETERMINATION OF CC PPS-1 RATE		
	Description	Amount 1
4.	Total allowable CCBHC costs (line 3)	$0
5.	Total CCBHC visits* (Daily Visits, column 1, line 4)	0
6.	Unadjusted PPS rate (line 4 divided by line 5)	$0
7.	Medicare Economic Index (MEI) adjustment from midpoint of the cost period to the midpoint of the rate period	0.000%
8.	CC PPS-1 rate (line 6 adjusted by factor from line 7)	$0
* Total should reflect the total count of CCBHC visits provided and not be restricted to Medicaid visits		
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End of Worksheet		

Determination of CC PPS-1 Rate

Requires input of MEI to trend data

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/MarketBasketData.html

Certification

MEDICAID COST REPORT

for Certified Community Behavioral Health Clinics

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL, AND ADMINISTRATIVE ACTION; FINE; AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED DIRECTLY OR INDIRECTLY THROUGH THE PAYMENT OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL, AND ADMINISTRATIVE ACTION; FINES; AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY OFFICER OR ADMINISTRATOR IS REQUIRED.

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and that to the best of my knowledge and belief, this report and statement are true, correct, complete, and prepared from the books and records of the Provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in the cost report were provided in compliance with such laws and regulations.

Signature of Officer:	
Title:	
Clinic:	
Medicaid ID:	
From Period:	
To Period:	
Preparer (If other than Officer):	

OMB #0398-1148 CMS-10398 (#43)

End of Worksheet

- Cost reports must include certification from the CEO, CFO or an authorized delegate. Cost reports will be rejected and returned for re-submission.

QUALITY BONUS PAYMENTS

- Rewards providers for improved quality of care
- Required measures = all 6 required quality measures
- State is currently reviewing additional measures for inclusion into the QBP
- QBP Methodology is currently under development, details include payment triggers, amount and frequency

QUALITY BONUS PAYMENTS – MEDICAID ADULT AND CORE SET MEASURES (REQUIRED)

Acronym[1]	Measure	Measure Steward[2]	QBP Eligible Measures	Required QBP Measures
FUH-AD	Follow-Up After Hospitalization for Mental Illness (adult age groups)	NCQA/HEDIS	Yes	Yes
FUH-CH	Follow-Up After Hospitalization for Mental Illness (child/adolescents)	NCQA/HEDIS	Yes	Yes
SAA-AD	Adherence to Antipsychotics for Individuals with Schizophrenia	NCQA/HEDIS	Yes	Yes
IET-AD	Initiation and Engagement of Alcohol & Other Drug Dependence Treatment	NCQA/HEDIS	Yes	Yes
NQF-0104	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA-PCPI	Yes	Yes
SRA-CH	Child and Adolescent MDD: Suicide Risk Assessment	AMA-PCPI	Yes	Yes

PPS/MANAGED CARE IMPLEMENTATION

States have 2 Options:

1. Incorporate the PPS rate into the capitation rate
2. Make wrap payments up to PPS

Options are currently under review

CCBHC PPS RESOURCES

- Nevada CCBHC Website:

  http://dpbh.nv.gov/Reg/CCBHC/CCBHC-Main

  Contains:

  - Nevada CCBHC Cost Report Template
  - CCBHC Cost Report Instructions
  - Preliminary List of CCBHC Allowable Services "Proposed Allowable CCBHC Services Grid"
  - Link to CMS CCBHC website

QUESTIONS?

PLEASE SUBMIT COST REPORT QUESTIONS TO:

Rates@dhcfp.nv.gov